LifeStyle Dentistry
Ann Hubbs D.D.S., P.A.

479-636-8700

www.lifestyledentistrynwa.com

Patient Information

Today's Date: _____

Patient Name: _____Preferred Name _____

Last First MI

☐Male ☐Female ☐ Married ☐Single ☐Child ☐Other

Social Security #:_____DL:_____

Phone (Home): _____Cell: _____Work: _____

Birth Date: _____ Email: _____

Preferred Contact Method: ☐ Home Number ☐Cell Number ☐Email ☐Text

Preferred Appointment Confirmation Method: ☐ Home Number ☐ Cell Number ☐Email ☐ Text

Preferred Method to Schedule Future Appointments: ☐ Home Number ☐ Cell Number ☐Email ☐ Text

Home Address: _____

Street City/State Zip Code

Work Address: _____

Street City/State Zip Code

Employer Name: _____ Position: _____ How long there? _____

Please list other members of your immediate family who are patients in our office_____

Referral Information

Can we thank someone for referring you?
Family Member_____
Coworker _____
Friend_____
Doctor_____

Or did you find us on your own?
___ Website
___ Insurance Company
___ Location/Drive-by
___ Post Card ____ Other_____

What is the reason for your visit today? _____

Date of Last Dental Visit: _____

- **Why did you leave your previous dentist? _____**
- **Are you interested in whitening your teeth? ☐ Yes ☐ No**
- **If you could change your smile, what would you do? _____**

We routinely use latex products for your safety. If you have a known sensitivity or allergy to latex products, please notify us prior to being called back to the treatment room.

Due to Laser, Radiation, Digital Scanning & Hipaa Compliance ONLY the patient being treated will be allowed and the treatment room & NO Cellphone Use. Thank you

Billing and Insurance Form

Billing and Insurance

Primary Insurance		Insurance provider#:		
Insurance Company		Plan		
Plan Number	Group number	Insured's Employer/School		
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number	
Insured's Address		City	State	City
Insured's Social Security Number		Insured's Birthdate		

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient	
Address	City	State	ZIP

_____ _____

Signature of Patient or Authorized Guardian Date

HEALTH QUESTIONNAIRE

Today's Date **Patient's Name** **Birthdate**

____/____/_____ _____ ____/____/_____

Name of person completing form (if different from patient) and relation to patient: _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality of care. All information you provide will be kept confidential

****PLEASE ANSWER BY MARKING Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION IF YES PLEASE EXPLAIN**

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of Last check up by physician: ____/____/_____
4. Are you currently in a physician's care? ..... Y N

If so, what for? _____

Treating Physician's Name: _____ Phone Number: _____

5. Have you had any serious illness, operations, or hospitalizations? ..... Y N

If so, describe and give approximate dates: _____

_____

_____

6. Have you ever had intravenous sedation or general anesthesia? ..... Y N

Were there any adverse effects? ..... Y N

7. Do you generally tolerate dental treatment well? ..... Y N

8. **DO YOU HAVE OR HAVE YOU EVER HAD:**

A. Heart disease that was detected at birth? ..... Y N

B. Rheumatic fever or Rheumatic heart disease? ..... Y N

C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? ..... Y N

D. Lung Disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? ..... Y N

E. Neurological Disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)? ..... Y N

F. Blood Disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)? ..... Y N

G. Liver Disease (jaundice, hepatitis)? ..... Y N

H. Kidney Disease? ..... Y N

I. Diabetes? ..... Y N

J. Thyroid Disease (hypothyroidism, tumor)? ..... Y N

K. Arthritis? (Which Joints?) ..... Y N

L. Stomach ulcers or Intestinal problems? ..... Y N

M. Glaucoma? ..... Y N

N. Frequent or recurring mouth sores? ..... Y N

O. Implants/artificial joints anywhere in your body? (Heart valve, hip, knee)? ..... Y N

P. Radiation (X-ray treatment for cancer) in head and neck region? ..... Y N

Q. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth? ..... Y N

R. Sinus or nasal problems? ..... Y N

S. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N

T. Recurrent infections of any kind? ..... Y N

*9. **ARE YOU TAKING OR USING ANY OF THE FOLLOWING**

A. Antibiotics? ..... Y N

B. Anticoagulants (blood thinners)? ..... Y N

C. Thyroid medications? ..... Y N

D. Antihistamines, decongestants? ..... Y N

E. High blood pressure or heart medication? ..... Y N

F. Steroids? …… Y N
G. Tranquilizers, antidepressants? ……..Y N
H. Stomach or GI medications (antacids, etc.)? …….. ……Y N
I. Cholesterol reducing drugs? ……..Y N
J. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain relievers? ……..Y N
K. Weight reduction pills or diet aids (over the counter or "natural" products)? ……Y N
L. Vitamins, Natural remedies (ginko biloba, ephedra, ginseng, etc.)? ….Y N
M. Marijuana, cocaine or other "recreational" drugs? ……Y N
N. Any other regular medications, pills, supplements or drugs? ……..Y N

***PLEASE LIST ALL CURRENT MEDICATIONS HERE** _____

_____

_____

10. **ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:**

A. Local anesthetic (Novocaine -like drugs)? ……..Y N
B. Penicillin, Amoxicillin, Cephalosporins? ……...Y N
C. Other antibiotics? ……Y N
D. Barbiturates, sedatives? …… Y N
E. Aspirin, ibuprofen, NSAIDS, or other pain medicines? …… ……Y N
F. Codeine or other narcotics or opioids? ……Y N
G. Latex? …… Y N
H. Other allergies or reactions? …….. Y N

Please List: _____

11. Do you have hay fever, frequent skin rashes, etc.? ……...Y N
12. Do you use alcohol? How much per day? _____Y N
13. Do you smoke? …….. …..Y N

What product and how many per day? _____ For how long? _____

14. Do you use spit tobacco? ……. For how long? _____ Y N
15. Are you, or have you been, in a drug or alcohol recovery program? ……Y N
16. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? …..... Y N
17. Do you wish to talk to the doctor privately about anything? ……... Y N
18. Any additional comments? _____

19. **WOMEN**

A. Are you taking birth control pills? ……Y N
B. Are you pregnant, trying to become pregnant or any chance you might be pregnant?……..Y N
C. Are you BREAST FEEDING? ……..Y N
D. Are you taking hormonal replacement? ……Y N

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____/____/_____ _____ _____

Date Signature of person completing form Doctor's initials

Consent for Services and Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

GENERAL

Thank you for choosing our practice as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor

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WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, APPLE PAY CARE CREDIT AND LENDING CLUB.

DENTAL INSURANCE: Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your ***ESTIMATED*** co-payment on the day services are rendered. We will gladly file your insurance claim. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. After a statement of accounts has been sent and a balance is left on the account after 60 days, the credit card kept on file will be charged for any balance over 60 days.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All ESTIMATED portions and deductibles are due prior to treatment. In the event YOU insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment.

USUAL AND CUSTOMARY RATES

Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by Visa/MasterCard, American Express, Discover, Care Credit, Lending Club or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS

We respectfully ask that you give us a minimum of 48 hours notice to cancel or reschedule your appointment. There will be a Cancellation fee of $50.00 if 48 hours notice is not given by the patient. Please help us serve you better by keeping scheduled appointments.

AUTHORIZATION & RELEASE:

Please Choose One:

☐ I will be paying my estimated co-pay and any applicable deductible only at the time of treatment and my credit card number will kept on file. I hereby authorize Life Style Dentistry to keep my signature on file and to charge my credit card account for any and all dental treatment fees remaining after my insurance carrier has processed my claim, or any balance still remaining after 60 days. **Life Style Dentistry agrees to make every reasonable effort to advise me before this transaction is made**

☐ I will be paying in full at the time of service by one of the following: CASH, CHECK, CREDIT CARD, or 3 Party Financing (Please circle one). **Life Style Dentistry will file my insurance claim on my behalf and will request that the benefits be REIMBURSED TO ME DIRECTLY FROM MY INSURANCE COMPANY**

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize my personal payment information (checks or credit cards used to make payments on your account), to be kept on file, if needed, to make restitution on any balance over 60 days past due.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I agree to have any photos taken of me to be used for education, training and/or marketing.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:

Signature of patient, parent or guardian

Life Style Dentistry

Dr. Hubbs would like all of her patients to have knowledge of risks and benefits of dental procedures. We ask that you review the procedures listed and feel free to ask any questions. A treatment plan for all restorative work, which includes **anticipated fees** and treatment specific authorization, will be presented to you for your review and signature at the time treatment is recommended.

1. **Drugs and Medication**: Antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Risk of local anesthesia may include temporary or permanent numbness or bruising.
2. **Changes in Treatment:** During treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.
3. **Removal of teeth:** Alternatives will be explained to you (root canal therapy, crowns, and periodontal surgery, etc). The removal of teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. Some of the risks are pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. Further treatment by a specialist or even hospitalization if complications arise during or following treatment would be your responsibility.
4. **Crowns and Bridges:** Sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. You may wear temporary crowns, which may come off easily. You will need to be careful to ensure that they are kept on until the permanent crowns are delivered. The final opportunity to make changes to a new crown or bridge (including shape, fit, size, or color) must be done at the preparation appointment.
5. **Partials/Dentures:** They are artificial, constructed of plastic, metal and/or porcelain. The problem of wearing these appliances, including looseness, soreness, and possible breakage. Most partials require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial fee.
6. **Endodontic Treatment (Root Canal):** There is no guarantee that root canal treatment will save a tooth. Complications can occur from the treatment and occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. Occasionally additional surgical procedure may be necessary following root canal treatment (apicoectomy). This treatment may be done with an Endodontist.
7. **Periodontal Loss (Tissue & Bone**): This is a serious condition, causing gum and bone infection or loss and can lead to the loss of teeth. Alternative treatment will be explained to you (gum surgery, replacement, and/or extractions). Any dental procedure may have a future adverse effect on your periodontal condition. This treatment may be done with a Periodontist.
8. **Implants:** They are a permanent alternative to bridges, partials or dentures. This process involves the participation of an oral surgeon or a periodontist. Fees for his/her services are separate from our service fees. This process involves several steps and could last from 2-6 months before complete (depending on healing time needed). As with crowns, color may not match perfectly with natural teeth.
9. **Sealants:** There is no guarantee that a sealant will prevent all cavities. They do, however, form a hard shield that keeps food and bacteria from getting into tiny grooves and causing decay along the chewing surfaces of the back teeth. Occasionally sealants need to be replaced, since they do not last a lifetime. We do, however, warranty our sealants for 2 years as long as the patient is seen twice a year for the prophylaxis visits. Sealants can be done at any age as long as the teeth are free of decay and fillings. The doctor will determine the best time to have them done.
10. **Sedative Fillings**: Sedative fillings are temporary. They are placed if near caries exposure of the nerve is suspected. If the tooth becomes symptomatic after 4-6 weeks, it's likely the tooth will need a root canal or it may need to be extracted. If the tooth is asymptomatic after 4-6 weeks, than the root has not been exposed. The sedative filling allows the tooth to lay down reparative dentin and will enable the Doctor to remove the decay and restore the tooth.

Treatment risk: I understand that any time a restoration is performed there is a possibility of trauma to the nerve of the tooth, which could result in varying degrees of sensitivity and complications including but not limited to the following: cold sensitivity, biting sensitivity, abscess, pulp necrosis. Most of the symptoms usually resolve as the nerve heals. Complications may arise resulting in the need for additional treatment. This may include one or more bite adjustments, replacement of the restoration due to open margins discovered after final cementation, root canal treatment or tooth removal.

I have carefully read above conformed consent and fully understand all risks as it relates to my case.

Patient Signature or Guardian _____ Print Patient Name _____

Date _____

ANN HUBBS FAMILY DENTISTRY, INC
Life Style Dentistry
4001 Financial Parkway
Rogers, Arkansas 72758
479-636-8700

NOTICE OF PRIVACY PRACTICES

This notice is to inform you that your personal health information will only be used for purposes of treatment in our facility and will not be misused or disclosed by / to anyone outside of our practice. You may gain access to this information if you desire.

Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on April 14, 2003 and will remain in effect.
We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy or our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice**.**

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider who is currently providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you (i.e. insurance companies).

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization

You may give us written authorization to use your health information or to disclose it to anyone for any purpose (e.g. a family member picking up records, referral to dental specialist, etc.) If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care

We may use or disclose health information to notify, or assist in the notification of (included identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure or your health information, we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to that person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Relation Services: Our dental office does not use patient information for any marketing purposes. We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when it is required by law to do so (i.e. missing person, etc.)

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to lawfully authorize federal officials health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. You may request access by sending us a letter to the address at the end of this notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for any purpose, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing. It must explain why the information should be amended. We may deny your request under certain circumstances.

Questions and Complaints:

If you desire further information about our privacy practices or if you have questions, please contact us. If you are concerned that 1) we may have violated your privacy right, 2) you disagree with a decision we made about access to your health information, 3) in response to a request you made to amend or restrict the use or disclosure of your health information or 4) to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Ann Hubbs, DDS, Privacy Officer, Owner

Telephone: 479-636-8700

Address: 4001 WEST FINACIAL PARKWAY
ROGERS, ARKANSAS72758

I received and reviewed a copy of our Dental Practice's Privacy, Security, and Breach Notification Policies and Procedures.

I Understand that I should ask our Dental Practice's Privacy Officer If I have any questions about these policies and procedures.

Print name_____ _____ Signature_____

Date _____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

Authorization to Release Personal Protected Health Information to an Individual

Patient Full Name:_____

Patient Date of Birth:_____

I do not authorize the release of any dental information to *any individual* except for treatment, payment and health care operations as specified in Life Style Dentistry's Notice of Privacy Practices.

I hereby authorize the release and disclosure of my dental information to the following individuals. My authorization extends to all protected health information for general information purposes. The information that may be discussed includes but is not limited to: statements of charges or payments, records of all visits, records of visits for any and all dates, copies of records or reports provided to specialists, progress notes and consultation reports. I understand this authorization does not expire unless otherwise noted below.

(Please list the name of the individuals with whom we may discuss your protected dental information.)

Name	Relationship to Patient

This authorization is given freely with the understanding that: 1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. 2. A photocopy of fax of this authorization is as valid as the original. 3. I may revoke this authorization at any time, except where information has already been released. The revocation must be in writing. A revocation form is available from the receptionist. 4. Life Style Dentistry, its employees, officers, and dentist are hereby released from any legal responsibility or liability for disclosure of the above information to the extent of indicated and authorized herein. 5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization. 6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is not longer protected.

Patient Name _____ Signature_____

Date_____

Laser Assisted Prophy- Laser Bacterial Removal (LBR)

Dr. Hubbs and Registered Dental Hygienist here are committed to providing a superior level of dental care to you, your family, and your friends. This commitment requires staying current on all the latest science, research and technology available to provide the highest level of care. We have recently added a new procedure to your cleaning appointment to help fight periodontal disease and keep gums healthy.

We now know that approximately 80% of adults are affected with gum disease (aka: periodontal disease). Periodontal Disease is a bacterial infection in the pockets and gum tissue around teeth. The bacteria in your mouth are responsible for periodontal disease. Periodontal disease is associated with the following diseases: heart disease, diabetes, pulmonary disease, low birth weight and premature delivery, osteoporosis, Alzheimer's, pancreatic cancer, obesity, still birth and hypertension.

Diode Lasers are now being used safely, and comfortably to decontaminate the gum tissue and pockets around the teeth and prior to your dental cleaning and preventative care. The laser emits concentrated light energy, which kills unhealthy bacteria. This procedure is called Laser Bacterial Reduction (LBR). The major benefits of LBR are:

TO REDUCE EMLIMINATE BACTEREMIA- During the normal dental cleaning process and during the normal brushing and flossing, most patients will have some areas that may bleed. This allows bacteria that are present in all our mouths to flood into the bloodstream and sometimes settle in the weakened areas of or body. As stated above research shows that these bacteria that cause periodontal disease have now been linked to a growing number of other diseases. Using the laser prior to your dental cleaning allows us to remove the bacteria and reduce the bacteria and reduce the bacterial flow into your bloodstream.

TO PREVENT CROSSCONTAMINATION- Infection in one area of your mouth can be transferred to other areas. Decontamination minimizes the chance that we may inadvertently pick up bacterial infection in one area of your mouth and move it to other areas.

TO KILL PERIODONTAL DISEASE BACTERIA- And stop their infections before they will cause destruction of loss of attachment around your teeth.

Laser Bacterial Reduction is painless and normally takes about 5 minutes for the entire mouth. We highly recommend that you take advantage of this service as part of your cleaning appointment.

Laser Bacterial Reduction is **$50** and at this time some dental insurance does not assist with payments for LBR. Unfortunately, insurance coverage is almost always behind the leading edge high tech health care.

Please ask Dr. Hubbs and your Dental Hygienist if you have any questions regarding this treatment, Please sign & date below if you like this service. Thank You

Due to Laser, Radiation, HIPAA Compliance & Digital Scanning, ONLY the patient being treated will be allowed in the treatment room.

_____ _____

Signature of Patient Date